H.6231
AN ACT TO INCREASE ACCESS AND AFFORDABILITY OF HEALTH INSURANCE IN MASSACHUSETTS

FACT SHEET
8/1/96

H.6231, An Act To Increase Accessibilty and Affordability of Health Insurance in Massachusetts, includes the following major reforms to the non-group (individual) insurance market and the small group market.

NON GROUP MARKET REFORMS

Guaranteed Issue of Non-Group Policies - No More Medical Redlining

Today, many people can be denied health coverage if carriers decide they are too old, too sick, live in a particular area, or if they have a preexisting medical condition. This bill would end this practice.

Consumer Choice - Increased Carrier Participation

This bill will ensure that carriers with a significant presence in the small group market participate in the non-group market. As a result, consumers will be able to choose a non-group product from a wide array of health insurance carriers.

Guaranteed Renewabilty - No Cancellations for Medical Conditions

Presently,most carriers are not obliged to renew health insurance coverage after an insured gets sick. As a result, consumers are at risk of losing their health insurance just when they need it the most. This bill will remove consumers' fear of health insurance cancellation by requiring renewal, regardless of medical experience.

Portability of Health Insurance Coverage

This bill prevents individuals who are continuously insured from losing their insurance coverage when they change jobs or go from group insurance to individual insurance. As a result, consumers will no longer be locked into a particular job because they fear losing their insurance coverage.

Rate Bands for Age and Geography

To encourage younger people to buy insurance, the bill permits a variation in rates based upon age. Up through November 30, 1999, the allowable rate band for age will be 1.33:.67 (2:1). As of December 1, 1999, this rate band will be 1.2:.8 (1.5:1).. Similarly, differences in health care costs in different regions of the state are reflected in a variation in rates based upon geography. The bill would eliminate rating based upon medical condition and gender.

A Standard Benefits Plan With a Prescription Drug Benefit

To ensure that consumers will receive value for their dollar when they buy an insurance policy, the bill contains a standard benefits plan. This plan includes a prescription drug benefit. This drug benefit is designed with a $25 copayment for brand name drugs and a $20 copayment for generic drugs to ensure that those with high prescription costs will be protected without a large increase in premium costs for all insureds. Out of pocket drug expenses are capped after 50 prescriptions and there are cost savings required for those who mail order. We included this prescription drug provision in the standard benefits plan because we were concerned that without this requirement, consumers would not have access to a prescription drug benefit in the non-group market. Carriers may offer a substitute plan, as long as it includes all of the benefits in the standard plan.

Ongoing Monitoring of the Non-Group Market and Better Consumer Information.

The bill establishes a non-group advisory board with nine members representing consumers, small business, insurers, the Division of Insurance and the Executive Office of Health and Human Services. The advisory board will publish a consumer guide to enable consumers to make more informed choices when purchasing non-group insurance. It will also issue an annual report on the status of the non-group insurance market to monitor the effects of the reform on access and affordability.

H.6231: SECTION BY SECTION SUMMARY
(8/1/96)

EMERGENCY PREAMBLE

CONFORMING AMENDMENTS - COMMERCIAL CARRIERS

SECTIONS 1-5 Conforming amendments: provide that provisions of new Chapter 176M of the General Laws govern in the case of inconsistencies with provisions of Chapter 175 applicable to commercial insurers.

CONFORMING AMENDMENTS - BLUE CROSS BLUE SHIELD

SECTIONS 6-8 Conforming amendments: eliminate references to rate approval process and provide that provisions of new Chapter 176M of the General Laws govern in the case of inconsistencies with provisions of Chapter 176A applicable to non-profit hospital service corporations.

SECTIONS 9-10 Conforming amendment: eliminates further references to rate approval process and duplication of provisions with new Chapter 176M of the General Laws; provides that provisions of new Chapter 176M of the General Laws govern in the case of inconsistencies with provisions of Chapter 176A applicable to non-profit hospital service corporations.

SECTION 11 Conforming amendment: eliminates medical underwriting by non-profit hospital service corporations governed under Chapter 176A of the General Laws.

SECTION 12 Conforming amendment: eliminates references to rate approval process.

SECTION 13 Conforming amendment: eliminates reference to rate approval process applicable to medical service corporations in Chapter 176B of the General Laws and duplication of provisions with new Chapter 176M of the General Laws.

SECTION 14 Conforming amendment: eliminates reference to rate approval process in Chapter 176B of the General Laws and duplication of provisions with new Chapter 176M of the General Laws.

SECTION 15 Conforming amendment: provides that provisions of the new Chapter 176M of the General Laws govern in the case of inconsistencies with provisions of Chapter 176B of the General Laws.

SECTION 16 Conforming amendment: eliminates references to rate approval process.

SECTION 17 Conforming amendment: provides that provisions of new Chapter 176M of the General Laws govern in the case of inconsistencies with provisions of Chapter 176B of the General Laws.

SECTION 18 Conforming amendment: eliminates further references to rate approval process and duplication of provisions with new Chapter 176M of the General Laws; provides that provisions of new Chapter 176M of the General Laws govern in the case of inconsistencies with provisions of Chapter 176B applicable to non-profit medical service corporations.

CONFORMING AMENDMENT - HEALTH MAINTENANCE ORGANIZATIONS

SECTION 19 Conforming amendment: provides that provisions of new Chapter 176M of the General Laws govern in the case of inconsistencies with provisions of Chapter 176G of the General Laws governing preferred provider organizations.

CONFORMING AMENDMENT - PREFERRED PROVIDER ORGANIZATIONS

SECTION 20 Conforming amendment: provides that provisions of new Chapter 176M of the General Laws govern in the case of inconsistencies with provisions of Chapter 176I of the General Laws governing preferred provider organizations.

SMALL GROUP REFORMS

SECTION 21 Eliminates definition of "association group policy" from Chapter 176J governing small group insurance, in conformance with Section 23.

SECTION 22 Eliminates sex as a case characteristic upon which rate differences in small group insurance may be based.

SECTION 23 Extends small group reform to groups with up to 50 insureds (is presently limited to groups of 25 insureds or fewer.)

SECTION 24 Eliminates gender as a basis upon which rate differences in small group insurance may be based.

SECTION 25 Eliminates exemption of association group policies from small group reform.

SECTION 26 1) Eliminates gender rating upon issue or renewal of a policy after August 15, 1996;

2) establishes phase-out adjustments for small groups with 26-50 employees;
3) reduces rate bands in the small group market from 2:1 to 1.5:1 as of December 1, 1999.

SECTION 27 Extends coverage similar to federal COBRA benefits to individuals covered by small group insurance in small groups of 2-19..

SECTION 28 Requires carriers in the small group market to file an annual statement of the number of eligible employees and dependents covered under such policies.

NON-GROUP REFORMS

SECTION 29 Enacts new Chapter 176M, Non-Group Health Insurance of the General Laws.

Section 1 Definitions section which defines guaranteed-issue health plans (medical, managed care and preferred provider), persons eligible to buy them and carriers authorized to offer them.

Section 2 **(a)** Requires that any non-group health plan offered, sold, issued, delivered, made effective or renewed by any carrier to any Massachusetts resident on or after August 15, 1996 must comply with the new Chapter 176M of the General Laws.

Carrier Participation

(b)(1) Requires carriers that cover more than 5000 eligible employees and dependents under small group plans to participate in the non-group market.

(b)(2)-(b)(4) 1) Requires carriers licensed under Chapter 176G (HMO's) that cover more than 5000 eligible employees and dependents under a small group plan to offer a guaranteed-issue managed care plan in the non-group market.

2) Carriers licensed under chapters 175, 176A and 176B (indemnity) that cover more than 5000 eligible employees and dependents under a small group plan would be required to offer a guaranteed-issue medical (indemnity) plan in the non-group market or , at their option, a guaranteed-issue preferred provider plan or both..

Standard Benefit Plans

(c) Requires the Executive Office of Administration and Finance to hire 3 contractors, including an actuary, to devise a standard benefits plan. (See Section 33 of bill regargarding payment of the costs of these contractors.)

(c)(1-(c)(4) 1) Outlines the standards and procedures for development and final approval of the three (medical, managed care and PPO) standard benefit plans.

2) Such plans must be based upon the small group prototype plan with a modified copayment for outpatient services. Each standard plan must contain, at least, certain medically necessary services, including prescription drugs. Outlines copayment levels, a cap on out of pocket expenses and mail order option for prescription drugs. Provides for annual review of the standard benefit plans by the non-group health insurance advisory board.

3) Carriers may offer a substitute for each type of standard benefits plan as long as it includes the benefits in the standard plan.

(c)(5) -(c)(6). 1) Permits carriers to renew closed plans for up to three years after August 15, 1996. Prohibits carriers from introducing new rating factors into closed plans;

2) Requires carriers to continue enrolling individuals into closed plans until September 1, 1997 (the date that coverage under guaranteed-issue plans becomes effective.) or to a later date should the Commissioner exercise her authority to postpone the effective date of coverage pursuant to subsection (b) of section three.

Guaranteed Issue and Elimination of Pre-Existing Condition Exclusions and Waiting Periods

Section 3 **(a)** 1) Prohibits the exclusion of eligible individuals and dependents based upon age, occupation, actual or expected health condition, claims experience, or medical condition of such person;

2) Prohibits pre-existing condition exclusions and waiting periods.

Open Enrollment Periods

3(b)(1)-(b)(5) 1) Establishes open enrollment periods (June 1-July 31 in Year 1 and September 1-October 31 in subsequent years.) Gives the Insurance Commissioner authority to postpone the open enrollment period in Year 1 if a substantial number of carriers are unable to participate because of substantial administrative delay. The Insurance Commissioner may penalize those carriers unable to participate in the first open enrollment period for reasons other than substantial administrative delay.

2) Sets standards for the enrollment of continuously insured individuals outside of the open enrollment period. Permits carriers to enroll insureds through intermediaries.

Age and Geography Rate Bands

Section 4 **(a)(1)-(a)(4)** Sets parameters for rate bands for age and geography. Up through November 30, 1999, the age rate band for guaranteed issue health plans shall be 1.33:.67 (2:1). As of December 1, 1999, the age rate band shall be 1.2:.8 (1.5:1) At all times the geography rate band shall be 1.2:.8.

Eligibility Requirements

(b) Prohibits carriers from knowingly issuing policies to ineligible individuals.

(c)-(e) Set standards for when a carrier is not required to offer or renew a guaranteed issue health plan and the manner in which a carrier may withdraw a plan from the market.

Rate Filing

Section 5 **(a)-(i)** 1) Provides for the filing of rates , adjusted for geography, age and benefit level in a manner to be prescribed by the Insurance Commissioner. Permits the non-group health insurance advisory board to include information from the filings in the annual consumer guide.

2) Requires heightened review for any carrier whose rate is not within two standard deviations of the average for that type of guaranteed-issue plan. Provides the carrier with an opportunity to demonstrate the reasonableness of the rate and an opportunity for a further adjustment for case mix before being required to undergo a public hearing process. Sets requirements for a public hearing process.

Voluntary Reinsurance Pool

Section 6 1) Establishes a voluntary reinsurance plan, subject to an agreement by five or more carriers to participate.

2) Establishes a governing committee, appointed by the Governor.

3) Sets premium rates for the plan. Provides for classification credits for those companies voluntarily writing non-group policies for those individuals with health conditions or health service availability problems that would be disproportionately represented in the plan.

PORTABILITY

SECTION 30 Establishes new Chapter 176N, Portability of Health Insurance of the General Laws

Section 1 Definitions section

Section 2 **(a)-(d)** Prohibits exclusion of any eligible insured on the basis of any actual or expected health condition

2) Limits pre-existing condition exclusions and waiting periods to six months with credit for time spent under a previous plan for continuously insured individuals.

(e) Provides that state or federal laws which provide more extensive coverage than that required under subsections (a) through (d) shall govern.

Section 3 Requires out of state health plans to apply the provisions of Section 2 to all Massachusetts residents.

Section 4 Requires the commissioner to promulgate regulations to enforce the new Chapter 176N.

NON-GROUP HEALTH INSURANCE ADVISORY BOARD

SECTION 31 1) Establishes a non-group health insurance advisory board within the Executive Office of Administration and Finance consisting of nine members, seven of whom shall be appointed by the Governor and two of whom shall be appointed by the Attorney General to staggered three-year terms.

2) Requires the board to advise the Insurance Commissioner on various issues regarding access and affordability in the non-group insurance market and to develop a consumer guide to be published annually.

3) Requires the board to develop a set of indicators against which to measure premium rates. Requires the board to make pertinent recommendations to the Insurance Commissioner and the Chairs of the Joint Committee on Insurance at least annually.

STUDY OF UNIFORM BILLING SYSTEM

SECTION 32 Authorizes the Joint Committee on Insurance to study the effectiveness of a single billing system for all insurers and report any recommendations to the House Clerk and the Senate Clerk before June 30, 1997.

SECTION 33` Appropriates funds for the hiring of contractors to design the standard benefits plan pursuant to section 2.

SECTION 34 Provides for an effective date of August 15, 1996